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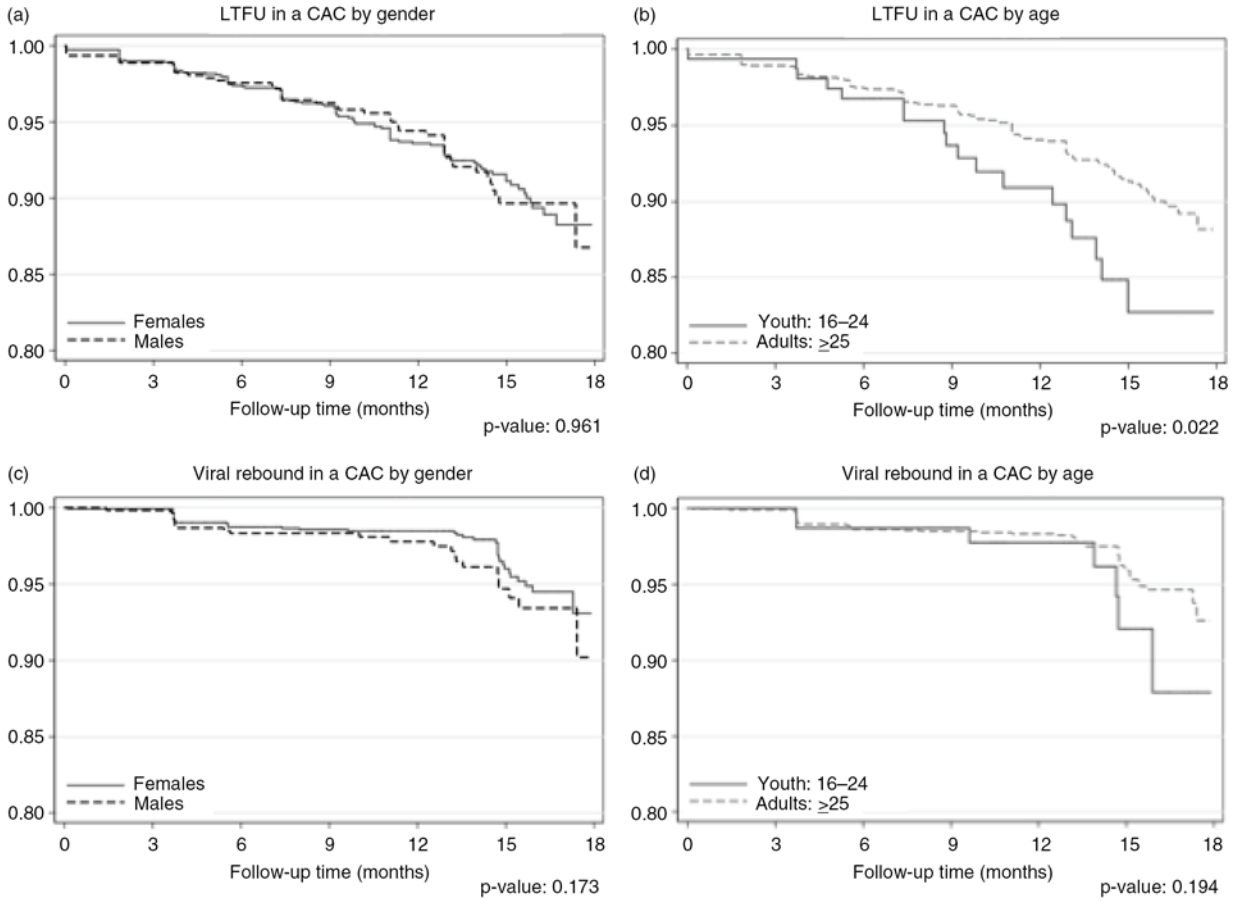

Abstract WEAD0101–Figure 1. Kaplan-Meier plots over the first 18-months in a Community-based Adherance Club: (a) LTFU by gender, (b) LFTU by age, (c) Viral rebound by gender, (d) Viral rebound by age.

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Introduction: Successful treatment for HIV infection requires sustained viral suppression (SVS). Patients with undetectable HIV-RNA levels have a significantly lower risk of clinical disease progression. And at community level viral suppression is important to reduce HIV transmission and the emergence of resistant strains. The study aimed to analyze the frequency and duration of viral suppression (VS) in the first cohort of people living with HIV/AIDS (PLWHA) under treatment. **Methods**: We retrospectively evaluated data from all PLWHA uninsured adults who initiated HAART through the National Program during 2004–2006 and followed-up until 2012. Patients with complete records in the National Laboratory Reporting System Data Base were included. The duration of VS was analyzed using survival analysis (Kaplan-Meier) in PLWHA who achieved viral suppression. Survival time was measured between the first control with viral load $\leq$400 copies/ml until the presence of first interruption or failure of viral suppression (FSV) with viral load $>$ 400 copies/ml. Persons lost to follow up and those without FSV were censored. R Software 3.0.3.was used. **Results**: During the study period a total of 6289 PLWHA had access to health care settings for initial evaluation and only 5142 received HAART. Of these, 4530(88%) achieved VS for variable time (responders) and 612 never presented VS (non-responders). Cumulative survival rate was analyzed in responders: 91.1% maintained VS up to one year, 84.6% up to two years, 80.2% to three years, 77.1% to four years, 74.1% to five years and 70.1% to six years. According to survival analysis, Kaplan-Meier curves presented lower duration of VS in young adult patients, females, persons in prisons and those who did not increase their CD4 above baseline. No differences were observed with baseline CD4 and viral load ($p < 0.05$).
Conclusions: This findings suggest that SVS as a programme indicator is feasible and useful for monitoring health care settings and ranking them like a control quality measure. SVS could also be included as another parameter in cascade of treatment measures.

http://dx.doi.org/10.7448/IAS.18.5.20408

WEAD0103

Entry into care following universal home-based HIV testing in rural KwaZulu-Natal, South Africa: the ANRS TasP 12249 cluster-randomized trial

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Introduction: In a Universal Test and Treat (UTT) strategy, entry into care soon after HIV diagnosis is crucial to achieve optimal population-antiretroviral treatment (ART) coverage. We evaluated the rate of, and factors associated with, entry into care following home-based HIV testing in a cluster-randomized trial of the effect of immediate ART on HIV incidence in rural KwaZulu-Natal, South Africa.
Methods: From March 2012 to May 2014, individuals $\geq$16 years in ten (2×5) clusters were offered home-based HIV testing; those ascertained HIV-positive were referred to TasP trial clinics and were offered universal and immediate ART (intervention clusters) or according to national guidelines (control clusters). Entry into care was defined as attending a TasP clinic within three months of referral among adults not actively in HIV care (no visit to local HIV programme within past 13 months). Associated factors were identified separately by sex, using multivariable logistic regression.
Results: Overall, 1205 adults (72.6% women) not actively in HIV care were referred to a TasP clinic. Of these, 405 (33.6%) attended a TasP clinic within three months (no difference between trial arms): 32.5% of women, 36.7% of men. Participants who ever visited the local HIV programme (n = 360) were more likely to enter into care than those who didn't (women: adjusted odd-ratio (aOR) 1.76, 95% Confidence Interval (1.26–2.45); men: 2.07 (1.18–3.64)). In women (n = 875), those less likely to attend a TasP clinic within three months had completed some secondary school (0.51 (0.33–0.79)) or at least secondary school (0.47 (0.29–0.76)) versus below primary school; were living 1–2 km from a TasP clinic (0.43 (0.30–0.62)) or 2–5 km (0.40 (0.27–0.61)) versus <1 km; didn't know anyone HIV+ within their family (0.60 (0.43–0.81)) and didn't agree that it is good to initiate ART as soon as possible if infected (0.47 (0.26–0.85)); among men (n = 330), none of the factors examined was significantly associated with entry into care.
Conclusions: Only one-third of HIV-positive adults referred after home-based HIV testing entered into care within three months in this rural South African community with a 30% HIV prevalence. Innovative interventions should be considered to ensure the success of a UTT strategy.

http://dx.doi.org/10.7448/IAS.18.5.20409

WEAD0104

Assessing the HIV care continuum in The Caribbean, Central and South America network for HIV epidemiology (CCASAnet): progress in clinical retention, cART use and viral suppression

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Introduction: Retention, combination antiretroviral therapy (cART) use and viral suppression are key stages in the HIV Care Continuum associated with delayed disease progression and reduced transmission. We assessed trends in these indicators within the large and diverse CCASAnet cohort over a decade.
Methods: Adults from CCASAnet clinical cohorts in Argentina, Brazil, Chile, Haiti, Honduras, Mexico and Peru contributed data from first visit between 2003 and 2012 until final visit, death, or the end of 2012. Retention was $\geq$2 HIV care visits in a year, >90 days apart. cART use was prescription of a regimen of $\geq$3 active antiretroviral agents in a year. Viral suppression was HIV-1 RNA < 200 copies/mL at last measurement in the year. cART use and viral suppression denominators were subjects with $\geq$1 visit in the year. Multivariable modified Poisson regression models were used to assess temporal trends and predict percentages meeting each indicator in each year, adjusting for age, sex, HIV transmission mode, cohort, calendar year and total time in care.
Results: Among 18,799 individuals contributing to retention analyses, 14,380 to cART use analyses and 13,330 to viral suppression

Abstract WEAD0104–Table 1. Person-years contributed and characteristics

Characteristic	Not Retained[a]	Retained[a]	p*	Not on cART[b]	On cART[b]	p*	Not virally suppressed[c]	Virally suppressed[c]	p*
Total	22,386	67,171	<0.01	11,565	57,312	<0.01	19,369	41,271	<0.01
Age (years)	33.9 (28.2, 40.6)	36.4 (30.0, 43.9)	<0.01	32.5 (27.1, 39.3)	35.5 (29.6, 42.4)	<0.01	33.5 (27.7, 40.4)	36.0 (30.1, 42.9)	<0.01
Male sex	14,238 (25.1)	42,487 (74.9)	0.35	8119 (16.5)	40,982 (83.5)	<0.01	13,493 (31.0)	29,981 (69.0)	<0.01
Female sex	8148 (24.8)	24,684 (75.2)		3446 (17.4)	16,330 (82.6)		5876 (34.2)	11,290 (65.8)	
MSM HIV risk	7050 (27.6)	18,503 (72.4)	<0.01	5079 (18.6)	22,225 (81.4)	<0.01	7537 (31.4)	16,489 (68.6)	<0.01
IDU HIV risk	820 (52.7)	735 (47.3)		203 (15.1)	1141 (84.9)		349 (29.3)	842 (70.7)	
Hetero HIV risk	8443 (29.2)	20,495 (70.8)		4800 (16.1)	24,945 (83.9)		8921 (34.4)	17,044 (65.6)	
Other/unk. HIV risk	6073 (18.1)	27,438 (81.9)		1483 (14.2)	9001 (85.9)		2562 (27.1)	6896 (72.9)	
Individual years in care	7 (4, 9)	7 (4, 9)	<0.01	6 (3, 8)	8 (5, 10)	<0.01	6 (4, 9)	8 (5, 10)	<0.01